DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/02/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO, 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER-COMPLETED A. BUILDING C 070033 B, WING 07/12/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 24 HOSPITAL AVE DANBURY HOSPITAL DANBURY, CT 06810 SUMMARY STATEMENT OF DEFICIENCIES (X4)·ID PROVIDER'S PLAN OF CORRECTION (EACH (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CORRECTIVE ACTION SHOULD BE CROSS-TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE. DATE DEFICIENCY) A 385 A 000 Responsible Leader: A 000 INITIAL COMMENTS Director of Patient Care Services who oversees Inpatient Services (Medical, Surgical, Critical An authorized substantial allegation survey Care and Behavioral units) will be ultimately concluded on July 12, 2018 in response to responsible for the corrective action and for Complaint #23489. The following Condition of overall and ongoing compliance. Participation was reviewed at Danbury Hospital: Plan/System Improvement: CFR 482,23 Nursing Services The hospital will ensure that patients are assessed by a registered nurse. Any changes in August 10, A 385 NURSING SERVICES A 385 behavior and/or questionable cardiac rhythm 2018 CFR(s): 482.23 changes will be reported to the appropriate covering Ilcensed independent practitioner. The hospital must have an organized nursing service that provides 24-hour nursing services. The Director of Patient Care Services and appropriate stakeholders will review and revise, The nursing services must be furnished or if indicated, the following policies: supervised by a registered nurse. Telemetry Standards of Care This CONDITION is not met as evidenced by: Telemetry Responsibilities of the RN The Condition of Participation for Nursing Electronic Nursing Documentation Patient Services has not been met based on medical Care Record Guidelines and Nursing Care record review, review of telemetry monitoring strips, review of facility policies and interviews for Chain of Command: Communication of 1 of 10 patients (Patient #1) who had a change in Patient Care Concerns condition and/or changes in telemetry monitoring tracings. The hospital failed to ensure that the RN Implementation: assessed the patient and/or notified the physician Clinical nursing staff on the inpatient medical, Aug 17, 2018 of changes in behavior and/or questionable surgical and critical care clinical units who are cardiac rhythm changes, responsible for assessments/reassessments and notification of changes in patient condition will. eview the following policies: Please refer to A 395 A 395 RN SUPERVISION OF NURSING CARE A 395 Cardiac Monitoring Policy / Danbury CFR(s): 482.23(b)(3) Electronic Nursing Documentation Patient A registered nurse must supervise and evaluate Care Record Guidelines and Nursing Care the nursing care for each patient. Plans Chain of Command: Communication of

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days. following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14. days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This STANDARD is not met as evidenced by:

Based on medical record reviews, review of facility documentation, review of facility policles Patient Care Concerns

Assessment / Reassessment Policy

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN U	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		PLETED
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				DANBURY, CT 06810		
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አ ኃሴሮ	A. II			A 385 continued		
A 395			A 3	95		
	change in condition (It to ensure the RN respossible cardiac rhythnoted in breathing/be personnel resulting in physician notification. Patient #1 was admitt with sepsis due to celleft lower extremity ar history that included a (CVA), diabetes and fictinical record dated 4 had a change in condidentified that the Patinfarct (stroke) involving	ted to the hospital on 4/2/18 dulitis with gangrene of the and had a past medical cerebral vascular accident hypertension. Review of the 4/6/18 noted that the patient lition and a head CT scan ient had a small acute ng the left occipital lobe.		Monitoring: A monthly audit of 50* reports of a cardiac rhythm from the telemetry technician to assigned registered conducted for adherence to the forpolicies: Cardiac Monitoring Policy / Department of Cardiac Monitoring Policy / Department of Cardiac Monitoring Document Care Record Guidelines and Plans Chain of Command: Communicate Care Concerns Assessment / Reassessment This audit will be conducted until the compliance is achieved for four components beginning September 1, 2 the audit reflect a score lower that education will occur with involved	monitor rurse will be bliowing canbury tation Patient Nursing Care nication of t Policy 90% pnsecutive 2018. Should n 90%, re-	Beginning Sept 1, 2018 and ongoing until compliance achieved
	12:42 AM identified the appropriate, drowsy, worientation, had normal heart rhythm, unlaboration shortness of breath, dianterior and posterior liters of oxygen. The record dated 4/7/ (patient care tech) #1 Patient was transferred at 3:10 AM. Review of facility documents the patient's heart most record to the patient's heart most properties.	iminished breath sounds r), and was on three (3) 18 identified that PCT documented that the ed to the chair with two staff umentation identified that enitor leads were off on 18 AM, 2:30 AM and 2:53 7 AM. The Patient's		The results of this audit will be rep Danbury Hospital Quality Improve Committee until compliance is acl Danbury Hospital Quality Improve Committee reports to the Quality Committee of the Board — who is responsible for the oversight of quassurance and performance impractivities for Western Connecticut Network. *a 100% audit will be completed s 50 reports occur within that month (approximately 140 calls/month of telemetry monitor technician to the registered nurse — an audit of 50 is over a 30% review)	ement hieved. The ement improvement ultimately uality ovement Health should less than cour from e assigned	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		E SURVEY
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A 390	Continued From page		A 3	95		}
	The telemetry strips of	dated 4/7/18 at 1:23 AM		Responsible Leader:		1
	identified the patient	had a heart rate 71 beats		Director of Patient Care Service Inpatient Services will be ultimated	es who oversees	
	per minute (bpm) wit	h a normal sinus rhythm and		for the corrective action and for	itely responsible	
	had questionable cha	anges in the Patient's rhythm		ongoing compliance.	Overall and	
	at 2:55 AM and 3:54	AM. In addition, an elevation		g compliante.		
		was noted at 3:54 AM from	ļ	Plan/System Improvement:		
		nd at 4:09 AM, the patient's		The hospital will ensure registe	red nurses	
	pulse was 29 bpm.			respond to a report of a possible	e cardiac rhythm	August 10,
				change and/or changes noted i	n	2018
		urse's note dated 4/7/18		breathing/behavior noted by un	licensed	
	indicated that Patient	#1 was found pulseless and		personnel. Any such changes in	n behavior and/or	•
	unresponsive at 4:05	AM and this coincided with		questionable cardiac rhythm ch reported to the appropriate cover	anges will be	
		noted and alert sent by		independent practitioner in a tin	enny acensed	
		The cardiac arrest code		in a production of the different	nory mariner,	
		he Patient was resuscitated		The Director of Patient Care Se	rvices and	
	from 4:12 AM on 4/7/	18 to 4:30 AM, had return of		appropriate stakeholders will re	view and revise,	
	spontaneous circulati	ion and was transferred to		if indicated, the following policie	es:	
		n dated 4/7/18 noted a left				
	cerebral artery infarct			 Telemetry Standards of Ca 	ire	
	anterior left parietal a	rea and ischemia of the left		 Telemetry Responsibilities 	of the RN	
	cerebellum. Patient#	1's prognosis was poor and		Electronic Nursing Docume	entation Patient	
		ently expired on 4/7/18 at		Care Record Guidelines ar Plans	nd Nursing Care	
	1:20 PM.			Chain of Command: Comm	and and an art	i
			1	Patient Care Concerns	initication of	·
		on 7/11/18 at 1:10 PM noted				
		nis shift on 4/6/18 at 11:00		Implementation:		Aug 17, 2018
		estless, constantly pulling at		Clinical nursing staff on the inpa	atient medical,	Aug 17, 2010
	his leads and trying to	get out of the bed, RN #1		surgical and critical care clinica	l units who are	
	indicated that PCT #1	Informed him at		responsible for assessments/re	assessments and	1
	approximately 3:30 A	M on 4/7/18 that the Patient		notification of changes in patier	it condition will	
	norted sick, ne asses	sed the Patient who "looked		review the following policies:		
	that time Pallen	t was a little tachycardic at		 Cardiac Monitoring Policy / 	Danhung	
		er identified that Monitor ed him of questionable		Hospital	January	
				Electronic Nursing Docume	entation Patient	***************************************
	was whom the poting	nd the only alert he received	į	Care Record Guidelines ar	nd Nursing Care	1
	of 20 hom) at 4:00 At	was bradycardic (heart rate	í i	Plans		f.
	come time, the to 1	on 4/7/18 and around the		 Chain of Command: Comm 	nunication of	:
		none rang on the unit as he		Patient Care Concerns		:
	was headed to the pa	ments room.		 Assessment / Reassessme 	ent Policy	1

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETED
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	ROVIDER OR SUPPLIER HOSPITAL SUMMARY STA	TEMENT OF DEFICIENCIES	ID	STREET ADDRESS, CITY, STATE, ZIP CODE 24 HOSPITAL AVE DANBURY, CT 06810 PROVIDER'S PLAN OF CORRECTION (EAR	07/12/2018
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	9:52 AM identified that messages back and for about leads being officithe cardiac monitor. Meshe spoke to RN #1 attachment as she was at one point. Monitor a called PCT #1 to chece patient's rhythm looke #1 was on break so an patient and the telement telementry was change stated she called RN #1 however, never receive calling a few times and called the red phone of rate was identified. Mo provide a specific time interview with PCT #1 noted that Patient #1 wo five shift at 11:00 PN restless and RN #1 was the patient "is ok, just #1 further identified the increasingly restless at the chair, however a short of breath. PCT # #1 that something was that RN #1 call RT (restled PCT #1 that the patient. PCT #1 indical about Patient #1, that the Patient. PCT #1 indical about Patient #1, that the Patient, She asked indicated that this was	Technician #1 on 7/12/18 at the was sending text orth to RN #1 and PCT #1 or cable disconnected from tonitor Technician #1 stated and PCT #1 about lead is unable to see the rhythm fechnician #1 stated she kneeds because the different, however, PCT nother PCT checked the etry was changed. After the different call despite did a little while after that, she in the unit when a low heart onitor Technician #1 did not of the events. on 7/11/18 at 1:36 PM was calm at the beginning of an 4/6/18, and became as notified who told PCT #1, as little short of breath". PCT	A 3:	Implementation (continued): In addition to the review of relevant policic clinical nursing staff on the inpatient med surgical and critical care clinical units whinvolved in the assessment/reassessmen patients and the reporting of a change in condition will review the principles of the Connecticut Hospital Association's coursentitled "Safety Starts with Me" with a foother CHAMP safety tools, particularly ARC Up. Should that tool not be successful, us the "Chain of Command" Policy is indicated Monitoring: A monthly audit of 30* medical records of patients who transferred to a higher level will be conducted for adherence to the foliolicies: Chain of Command: Communication Patient Care Concerns Assessment / Reassessment Policy These record reviews will focus on documentation of the assessment of a chepatient condition and notification of approcovering licensed independent practitions timely manner. This audit will be conducted until 90% compliance is achieved for four consecution months beginning September 1, 2018. Stithe audit reflect a score lower than 90%, education will occur with involved clinical	ical, o are nt of patient e cus on CC it se of red. f of care Beginning Beginning Sept 1, 2018 and ongoing until compliance achieved mange in appriate er in a

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	SURVEY PLETED
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A 20E	0 ") "			A 395 continued		;
A 395	Terrando a richin pas		A 3	95		
	RN #3 came to assis	st with the patient then a code	į	The results of this audit will		
		stated she did not know to		Danbury Hospital Quality Im		
	notify the charge nu	rse when RN #1 and RN #2		Committee until compliance		1
	failed to respond.			Danbury Hospital Quality Im		
				Committee reports to the Qu		
		2 on 7/19/18 at 9:11 AM		Committee of the Board – w		
		f1 did mention that her	***************************************	responsible for the oversigh		
	"patient was restles:	s and that she (PCT#1) had		assurance and performance		
		lout of the room. When PCT	1	activities for Western Conne	ecticut Health	
	#1 expressed seriou	is concern for Patient #1, RN	į	Network.		
		IRN #1 caring for the patient	ļ.			
		n duty, RN #3 that she was	ĺ	*a 100% audit will be compl	eted should less than	ו
		wasn't doing well and both	i e	30 transfers to a higher leve	of care have	
		aid that Patient #1 was fine.		occurred within that month		
		ent to check Patient #1, who		(approximately 60 transfers	to bloken leval of	
		i chair and had agonal	-	care/month occur – an audit		
		dicated that RN #1 was]
		t's code status, PCT#1		100% is over a 30% review))	
		#1 was a full code, and RN				
	#2 directed that a "C	Code" be called.	1			-
	Interview with MD#	1 on 7/11/18 at 11:54 AM			•	:
	noted that he would	expect to be notified if a		·		
	patient became incr	easingly restless and would				
	have directed that a	12 lead EKG be performed				
	with any questionab	le telemetry reading.				
	Interview with the Q	uality Specialist on 7/10/18 at				
		w of the Patient's record				
	f .	did not document the				
	assessed restless b	ehavior and did not document				
		on PCT #1's concerns. The	2 1 3			
	Quality Specialist fu	rther indicated that RN #1	į	-		
		provider know when the	1			
		e in condition, believed that				
		I tried to inform RN #1 of the				
	4	try changes, and a 12 lead				
		een performed. The Quality				
		entified that Monitor Tech #1				

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DAT	TE SURVEY MPLETED
		Awa a a a				С
		070033	B. WING _		0'	7/12/2018
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A 395	the telemetry box wa telemetry changes by call. The Quality Speinterviews with staff of identified RN #1 was status and a code wa. The facility policy for the RN noted to resp Monitor Technician. I service 10 West iden approach is used to RN is primarily respoduring his/her shift. T	I RN #1 a couple times after s changed for questionable ut, RN #1 did not pick up the cialist stated that her during the investigation aware of the patient's code as initiated immediately. telemetry responsibilities of ond to all calls from the The facility policy for scope of tified that an interdisciplinary provide patient care and the nsible to manage the patient the facility RN 1 job a major accountability to	A	395		
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August 10, 2018

Cheryl Davis, RN, BSN 410 Capitol Avenue P. O. Box 340308 Hartford, CT 06134

Dear Ms. Davis:

On behalf of Danbury Hospital, please accept the attached plan of correction in response to the July 12, 2018 State of Connecticut Department of Public Health survey. We pride our organizational participation in the Connecticut Hospital Patient Safety Collaboration as evidenced by our adoption of the principles of high reliability. In addition, we diligently review adverse events to identify issues that may lead to mandatory reporting requirements, and with complete transparency, bring them forward to the Department of Public Health on a timely basis as we did in this circumstance.

Thank you for the opportunity to review this case in greater detail. If you have any questions, please feel free to contact me via any of the contact methods noted in the signature line.

Sincerely,

Korrine Roth, MSN, CPHO FACHE

Administrative Director of Quality, Safety and Satisfaction

Work: (203) 739-7349 Cell: (203) 917-7974

Email: Korrine.roth@wchn.org

Department of Public Health (DPH) July 2018 Survey Findings

Title of Person Responsible for Monitoring Plan of Correction		Director of Patient Care Services who oversees Inpatient Services will be ultimately responsible for the corrective action and for overall and ongoing compliance.
Corrective Measure Effective Date		August 10, 2018
Plan of Correction (measures to prevent recurrence)		Responsible Leader: Director of Patient Gare Services who oversees Inpatient. Services will be ultimately responsible for the corrective action and for overall and ongoing compliance. Plan/System Improvement: The hospital will ensure registered nurses respond to a report of a possible cardiac rhythm change and/or changes noted in breathing/behavior noted by unlicensed personnel. Any such changes in behavior and/or questionable cardiac rhythm changes will be reported to the appropriate covering licensed independent practitioner in a timely manner. The Director of Patient Care Services and appropriate stakeholders will review and revise, if indicated, the following policies: Telemetry Standards of Care Telemetry Responsibilities of the RN Electronic Nursing Documentation Patient Care Record Guidelines and Nursing Care
Identified Violation	The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical Records (3) and/or (e) Nursing Service (1) and/or (i) General (6).	1. Based on medical record reviews, review of facility documentation, review of facility policies and interviews for one of ten patients who had a change in condition (Patient #1), the facility failed to ensure the RN responded to a report of a possible cardiac rhythm change and/or changes noted in breathing/behavior noted by unlicensed personnel resulting in a delay in assessment and physician notification. The finding includes: a. Patient #1 was admitted to the hospital on 4/2/18 Patient had a small acute infarct (stroke) involving the left occipital lobe. Patient #1 was transferred to 10W (stroke unit) on 4/6/18 at 4:53 PM. Review of RN#1's assessment dated 4/6/18 at 12:42 AM identified that the patient was calm, appropriate, drowsy, was unable to determine orientation, had normal heart sounds, a regular heart rhythm, unlabored respirations, no shortness of breath, diminished breath sounds (anterior and posterior), and was on three (3) liters of oxygen. The record dated 4/7/18 identified that PCT (patient care tech) #1 documented that the Patient was transferred to the chair with two staff at 3:10

Identified Violation	Plan of Correction (measures to prevent recurrence)	Corrective Measure Effective Date	Title of Person Responsible for Monitoring Plan of Correction
Review of facility documentation identified that the Patient's heart monitor leads were off on 4/7/18 at 1:22 AM, 1:48 AM, 2:30 AM and 2:53 AM, 3:26 AM and 3:27 AM. The Patient's telemetry box was	Plans Chain of Command: Communication of Patient Care Concerns		
changed at 2:55 AM. The telemetry strips dated 4/7/18 at 1:23 AM identified the patient had a heart rate 71 beats per minute (bpm) with a normal sinus rhythm and had questionable changes in the Patient's rhythm at		August 17, 2018	
questionable changes in the Patient's rhythm at 2:55 AM and 3:54 AM. In addition, an elevation of the Patient's pulse was noted at 3:54 AM from 72			
bpm to 93 bpm and at 4:09 AM, the patient's pulse was 29 bpm.	Cardiac Monitoring Policy / Danbury Hospital		
indicated that Patient #1 was found pulseless and unresponsive at 4:05 AM and this coincided with a	 Electronic Nursing Documentation Patient Care Record Guidelines and Nursing Care Plans 		
bradycardic event noted and alert sent by Monitor Technician #1. The cardiac arrest code sheet identified that the Batisatives for the first transfer.	 Chain of Command: Communication of Patient Care Concerns 		
4:12 AM on 4/7/18 to 4:30 AM, had return of	Assessment / Reassessment Policy		
spontaneous circulation and was transferred to the ICU. The CT scan dated 4/7/18 noted a left	In addition to the review of relevant policies, clinical nursing staff on the inpatient medical		
cerebral artery intarct (stroke) affecting the left anterior left parietal area and ischemia of the left	surgical and critical care clinical units who are		
cerebellum. Patient #1's prognosis was poor and the Patient subsequently expired on 4/7/18 at 1.20	patients and the reporting of a change in patient		
PM. Interview with RN #1 on 7/11/19 of 1:10 DM poted	Connecticut Hospital Association's course		
that when he began his shift on 4/6/18 at 11:00 DM Patient #1 was rections constants.	entitled "Safety Starts with Me" with a focus on the CHAMP safety tools, particularly ARCC it	***	
his leads and trying to get out of the bed. RN #1 indicated that PCT #1 informed him at	Up. Should that tool not be successful, use of the "Chain of Command" Policy is indicated.		
approximately 3:30 AM on 4/7/18 that the Patient looked sick, he assessed the Patient who "looked			
good" and the Patient was a little tachycardic at that time. RN #1 further identified that Monitor			
Tech #1 never informed him of questionable felemetry changes and the only alert he received			

190101000 0101001011	Identified Violation	
pari i acomi	Plar	

(measures to prevent recurrence) ın of Correction

Effective Date Corrective Measure

Monitoring Plan of Responsible for Title of Person

Correction

#1 that something was wrong and she suggested patient. PCT #1 indicated that she was so worried breath and did not enter the room to evaluate the told PCT #1 that the patient was fine, just short of that RN #1 call RT (respiratory therapist). RN #1 short of breath, PCT #1 stated she informed RN to the chair, however continued to be restless and increasingly restless and the patient was assisted #1 further identified that the patient became the patient "is ok, just a little short of breath". PCT restless and RN #1 was notified who told PCT #1 noted that Patient #1 was calm at the beginning of called the red phone on the unit when a low heart calling a few times and a little while after that, she stated she called RN #1 to check the leads, attachment as she was unable to see the rhythm her shift at 11:00 PM on 4/6/18, and became Interview with PCT #1 on 7/11/18 at 1:36 PM provide a specific timeline of the events. rate was identified. Monitor Technician #1 did not however, never received a return call despite telemetry was changed, Monitor Technician #1 patient and the telemetry was changed. After the #1 was on break so another PCT checked the patient's rhythm looked different, however, PCT called PCT #1 to check leads because the at one point. Monitor Technician #1 stated she she spoke to RN #1 and PCT #1 about lead about leads being off or cable disconnected from 9:52 AM identified that she was sending text was headed to the patient's room. same time, the red phone rang on the unit as he of 38 bpm) at 4:02 AM on 4/7/18 and around the Interview with Monitor Technician #1 on 7/12/18 at was when the patient was bradycardic (heart rate messages back and forth to RN #1 and PCT #1 the cardiac monitor. Monitor Technician #1 stated

> conducted for adherence to the following cardiac rhythm from the telemetry monitor A monthly audit of 50* reports of change in policies technician to assigned registered nurse will be Monitoring:

- Cardiac Monitoring Policy / Danbury Hospital
- Plans Care Record Guidelines and Nursing Care **Electronic Nursing Documentation Patient**
- Patient Care Concerns Chain of Command: Communication of
- Assessment / Reassessment Policy

than 50 reports occur within that month *a 100% audit will be completed should less

registered nurse - an audit of 50 cases or 100% is over a 30% review) telemetry monitor technician to the assigned (approximately 140 calls/month occur from

In addition:

policies: will be conducted for adherence to the following patients who transferred to a higher level of care A monthly audit of 30* medical records of

- Chain of Command: Communication of Patient Care Concerns
- Assessment / Reassessment Policy

occurred within that month than 30 transfers to a higher level of care have *a 100% audit will be completed should less

> compliance ongoing until 1, 2018 and Beginning Sept

achieved

about Patient #1, that when RN #1 did not help the

Identified Violation

(measures to prevent recurrence) Plan of Correction

Effective Date Corrective Measure

Monitoring Plan of Responsible for Title of Person

Correction

RN #2 indicated that RN #1 was unsure of the seated in a Geri chair and had agonal breathing. stated she went to check Palient #1, who was #1 and RN #3 said that Patient #1 was fine. RN #2 another nurse on duty, RN #3 that she was got up and asked RN #1 caring for the patient and expressed serious concern for Patient #1, RN #2 going in and out of the room. When PCT #1 #2 didn't respond, PCT #1 yelled out for help and "Code" be called. #1 was a full code, and RN #2 directed that a patient's code status; PCT #1 verified that Patient informed Patient #1 wasn't doing well and both RN was restless and that she (PCT #1) had to keep identified that PCT #1 did mention that her "patient notify the charge nurse when RN #1 and RN #2 was called. PCT #1 stated she did not know to RN #3 came to assist with the patient then a code Patient, She asked RN #2 to help and RN #2 indicated that this was not her patient. When RN Interview with RN #2 on 7/19/18 at 9:11 AM failed to respond

EKG should have been performed. The Quality questionable telemetry changes, and a 12 lead Patient had a change in condition, believed that should have let the provider know when the assessed restless behavior and did not document with any questionable telemetry reading. Monitor Tech #1 had tried to inform RN #1 of the Quality Specialist further indicated that RN #1 assessments based on PCT #1's concerns. The indicated that RN #1 did not document the have directed that a 12 lead EKG be performed patient became increasingly restless and would noted that he would expect to be notified if a 12:37 PM and review of the Patient's record interview with the Quality Specialist on 7/10/18 at Interview with MD #1 on 7/11/18 at 11:54 AM

> care/month occur - an audit of 30 cases or (approximately 60 transfers to higher level of

education will occur with involved clinical staff compliance is achieved for four consecutive the audit reflect a score lower than 90%, remonths beginning September 1, 2018. Should These audits will be conducted until 90%

activities for Western Connecticut Health assurance and performance improvement the Danbury Hospital Quality Improvement responsible for the oversight of quality Committee of the Board - who is ultimately Committee until compliance is achieved. The Committee reports to the Quality Improvement Danbury Hospital Quality Improvement The results of these audits will be reported to

ldentified Violation	Plan of Correction (measures to prevent recurrence)	Corrective Measure Effective Date	Title of Person Responsible for Monitoring Plan of Correction
Specialist further identified that Monitor Tech #1			
stated she had called RN #1 a couple times after			
the telemetry box was changed for questionable			
telemetry changes but, RN #1 did not pick up the	,		
call. The Quality Specialist stated that her			
interview with staff during the investigation			
identified RN #1 was aware of the patient's code			
The facility policy for telemetry responsibilities of			
the RN noted to respond to all calls from the			
Monitor Technician. The facility policy for scope of			
service 10 West identified that an interdisciplinary			
approach is used to provide patient care and the			
RN is primarily responsible to manage the patient			
description identified a major accountability to			
perform assessments in an ongoing and			
systematic manner.	TO THE PROPERTY OF THE PROPERT		